



## FLEXIBLE BENEFITS FAMILY STATUS CHANGE APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration  
26th Floor, William R. Snodgrass TN Tower • Nashville, Tennessee 37243 • 615.741.3590 or 1.800.253.9981 • Fax: 615.741.8196

This application is to be completed by the employee and the department. See the reverse side for guidelines.

### EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial	Social Security Number
Home Address		City	State Zip Code
Department Name		Dept ID / Budget Code	Work Phone Employee ID (if known)

### TYPE OF FAMILY CHANGE INCURRED

- |  |  |
|--|--|
| <input type="checkbox"/> Marriage                                      | <input type="checkbox"/> Ineligibility of dependent (due to age, marriage or loss of full-time student status) |
| <input type="checkbox"/> Divorce                                       | <input type="checkbox"/> From full-time to part-time employment or vice versa (employee or spouse)             |
| <input type="checkbox"/> Legal separation                              | <input type="checkbox"/> Unpaid leave of absence (employee or spouse)  |
| <input type="checkbox"/> Death (employee, spouse or dependent)         | <input type="checkbox"/> Significant change in health coverage due to spouse's employment                      |
| <input type="checkbox"/> Birth or adoption of child                    | <input type="checkbox"/> Other (specify) _____   |
| <input type="checkbox"/> Termination of participant's state employment |  |
| <input type="checkbox"/> Beginning or end of employment of spouse      |  |

### CHANGE REQUESTED

<b>State Group Insurance Premium</b>	<b>Medical Expense Account</b>	<b>Dependent Care Account</b>
<input type="checkbox"/> I am <b>terminating</b> my medical insurance  -----  <input type="checkbox"/> I am <b>terminating</b> my dental insurance <input type="checkbox"/> I am <b>adding</b> dental insurance	<input type="checkbox"/> Terminate contributions  <input type="checkbox"/> Start account: I wish to contribute _____ <b>annually</b> , to be taken from each of my remaining regular paychecks  <input type="checkbox"/> Change existing account: I wish to change from _____ per year to _____ per year to be taken from each of my regular paychecks	<input type="checkbox"/> Terminate contributions  <input type="checkbox"/> Start account: I wish to contribute _____ <b>annually</b> , to be taken from each of my remaining regular paychecks  <input type="checkbox"/> Change existing account: I wish to change from _____ per year to _____ per year to be taken from each of my regular paychecks

### AUTHORIZATION

This is to certify that on \_\_\_\_\_ (date of event), I incurred the family status change(s)\* checked above and, therefore, wish to change my plan benefits as indicated. I understand that the change requested must be consistent with the family status change event.

\* You must submit documentation of your change of family status. Examples of documentation include: marriage, birth, or death certificates; divorce decrees; notices of legal separation; proof of change in spouse's employment; or adoption papers.

Employee Signature	Date
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### OFFICIAL USE ONLY

To be completed by Departmental Human Resource Officer	To be completed by Benefits Administration
Name _____	Date _____
Dept. _____	No. Paychecks Remaining _____
Mailing Address _____	Payroll Check Effective Date - Insurance _____
Phone _____	Payroll Check Effective Date - Reimb. Acct(s) _____

Return to Benefits Administration at the address listed above. Keep a copy for your records.

For questions regarding enrollment or a family status change, please call Benefits Administration at 615.741.3590 or 1.800.253.9981.  
For questions regarding reimbursement requests, please call the Department of Treasury at 615.532.3170 or 1.877.681.0155.